

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #: M4-08-3543-01
HARRIS METHODIST OF FORT WORTH 3255 W PIONEER PKWY ARLINGTON TX 76013	
Respondent Name and Box #:	
TEXAS MUTUAL INSURANCE CO. Rep Box # 54	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The patient came into our ER at 10:00 PM, it seems pretty safe to say that when the patient called for his treating physician, they were told by whoever was on call at that time of night to go the ER if they felt they could not wait till the morning. We do not feel that the carrier should be allowed to deny claims for our ER services when the services are provided at this time of night. We could understand if this was done during regular operating times, but as this was at or after 10:00 in the evening, it does not seem logical that the treating physician would have gotten out of his home to go see this patient at that time."... "We respectfully ask that you reprocess this admit at the 75% of billed charges as a form of punishment to the carrier for the denial."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1,459.31
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier maintains its position on these issues in this dispute as outlined by its EOBs contained in the requestor's DWC-60 packet."... "This carrier denied the charges in dispute for date of service 8/23/2007 due to the fact the treatment was not recommended or approved by the treating doctor."... "The emergency room visit rendered is five months post injury. According to the medical records provided...the reason for the visit was due to neck pain and pain down left arm. The treatment was not provided as an emergency and/or immediate post-injury medical care. The injured worker should have sought treatment through the treating doctor or record for continued treatment."... "The requester has not provided documentation of an emergency as defined in TWCC Rule 133.1(7)."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/23/2007	CAC-B7, 242, CAC-W4, CAC-16, 225, 891	Emergency Room Services	\$1,459.31	\$0.00
Total /Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
 - 242 – Not treating doctor approved treatment.
 - CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
 - CAC-16 – Claim/service lacks information which is needed for adjudication. Additional information is supplies using remittance advice remarks codes whenever appropriate.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 891 – The insurance company is reducing or denying payment after reconsideration.
2. Texas Labor Code §408.023(f) states “Except in an emergency or for immediate post-injury medical care as defined by commissioner rule, or as provided by Subsection (h), (i), or (j), each doctor who performs functions under this subtitle, including examinations under this chapter, must hold a certificate of registration and be on the division's list of approved doctors in order to perform services or receive payment for those services.” The disputed services are emergency room services. Therefore, for emergency treatment, the physician is not required to be on the Approved Doctor’s List (ADL) or obtain a referral from the treating doctor per Section §408.023(f).
3. Division rule at 28 TAC §133.2(3), effective May 2, 2006, 31 TexReg 3544, defines “(3) Emergency -- Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” A review of the requestor’s documentation finds that the requestor did not document the existence of a medical emergency as defined by Division rule at 28 TAC §133.2(3).
4. This dispute relates to emergency room services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(5), effective August 1, 1997, 22 TexReg 6264, states that “Emergency services that do not lead to an inpatient admission are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services”...
5. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... This request for medical fee dispute resolution was received by the Division on February 8, 2008. Review of the requestor’s position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
8. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the submitted documentation supports the requestor position for each disputed fee issue.”... Review of the requestor’s documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iv).
9. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to requests for medical fee dispute resolution filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”... The requestor’s position statement asserts that “We respectfully ask that you reprocess this admit at the 75% of billed charges as a form of punishment to the carrier for the denial.” However, the requestor does not explain how payment of 75% of billed charges would result in a fair and reasonable reimbursement for the

services in dispute. The requestor did not submit documentation to support the rationale for increased reimbursement. The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. The request for additional reimbursement is not supported. Additionally, the Division has determined that a reimbursement methodology based upon a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the Acute Care Inpatient Hospital Fee Guideline adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv), and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031, §408.023 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §133.2
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

12/11/2009

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.